Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VA Eastern Kansas HCS (VAMC Leavenworth - 677A4)

VISN 15

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 217

2. Point-in-time estimate of Veterans who are Chronically Homeless: 31

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **217** (point-in-time estimate of homeless veterans in service area) **X 16%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 89%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 31** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	0	0
Transitional Housing Beds	15	21
Permanent Housing Beds	0	40

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Open HUD-funded unit. Apply for HUD supportive housing vouchers. Work with Director PH to draft grant to state of Kansas for TBRA vouchers for April 2005.
Help with Transportation	Submit grant to Department of Labor for transportation assistance. Identify Continuum of Care member to attend mid-America Regional Counsel planning meetings on transportation issues.
Immediate shelter	Research "safe house" shelter programs for homeless individuals with mental health and substance abuse issues. Identify finding options for shelter beds in this area.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 12 Non-VA staff Participants: 91%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.44	40%	2.25	1
2	Help with transportation	1.78	40%	2.82	11
3	Dental care	2	20%	2.34	2
4	Eye care	2.11	0%	2.65	5
5	Glasses	2.11	0%	2.67	6
6	Child care	2.33	0%	2.39	3
7	Guardianship (financial)	2.4	0%	2.76	9
8	Drop-in center or day program	2.5	10%	2.77	10
9	Help managing money	2.5	0%	2.71	7
10	Legal assistance	2.56	0%	2.61	4
11	Halfway house or transitional living facility	2.6	20%	2.76	8
12	Job training	2.78	0%	2.88	14
13	Emergency (immediate) shelter	2.8	10%	3.04	20
14	Detoxification from substances	2.89	0%	3.11	22
15	Welfare payments	3.22	0%	2.97	16
16	Personal hygiene (shower, haircut, etc.)	3.3	10%	3.21	26
17	Help getting needed documents or identification	3.3	0%	3.16	23
18	Treatment for substance abuse	3.33	0%	3.30	28
19	SSI/SSD process	3.33	0%	3.02	19
20	Education	3.33	0%	2.88	13
21	Help with medication	3.44	10%	3.18	24
22	VA disability/pension	3.44	0%	3.33	29
23	Help with finding a job or getting employment	3.44	10%	3.00	17
24	Discharge upgrade	3.5	0%	2.90	15
25	Women's health care	3.56	0%	3.09	21
26	AIDS/HIV testing/counseling	3.56	0%	3.38	30
27	TB testing	3.67	0%	3.58	36
28	TB treatment	3.67	0%	3.45	33
29	Family counseling	3.78	0%	2.85	12
30	Hepatitis C testing	3.78	0%	3.41	32
31	Treatment for dual diagnosis	3.89	0%	3.01	18
32	Clothing	4	0%	3.40	31
33	Services for emotional or psychiatric problems	4	0%	3.20	25
34	Food	4.2	10%	3.56	35
35	Spiritual	4.2	0%	3.30	27
36	Medical services	4.22	0%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.08	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.2	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.4	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.4	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.33	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.1	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.89	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.09	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.33	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.7	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.9	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.78	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.67	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.56	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.25	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.5	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.75	1.84

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CHALENG 2004 Survey: VAH Columbia, MO - 543

VISN 15

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 404

2. Point-in-time estimate of Veterans who are Chronically Homeless: 160

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **404** (point-in-time estimate of homeless veterans in service area) **X 41%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 96%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 160** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	463	350
Transitional Housing Beds	483	241
Permanent Housing Beds	100	490

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 7

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Continue to apply for federal funding opportunities. Educate and work with coalition- and City of Columbia-funded grant writer in applying for VA funding. Encourage partnerships with Columbia Boone County Basic Needs Coalition and local developers. Coalition will submit for 501(c)3 status to allow additional access to funding sources.
Immediate shelter	Assess community readiness and availability for a "safe haven" shelter in Boone County (for chronic homeless who may continue to use alcohol and/or other drugs); we will conduct a study through strategic planning in 2005, then look at "best practices" to begin.
Dental Care	Will attempt to establish informal memorandum of understanding with division of family services to expedite Medicaid claims for veterans who are homeless and are involved in any of the requiring programs.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 69 Non-VA staff Participants: 43% Homeless/Formerly Homeless: 32%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.31	23%	2.25	1
2	Dental care	2.32	14%	2.34	2
3	Eye care	2.37	11%	2.65	5
4	Glasses	2.41	3%	2.67	6
5	Emergency (immediate) shelter	2.49	31%	3.04	20
6	Halfway house or transitional living facility	2.52	22%	2.76	8
7	Legal assistance	2.55	3%	2.61	4
8	Child care	2.7	2%	2.39	3
9	Help with transportation	2.71	11%	2.82	11
10	Help managing money	2.72	6%	2.71	7
11	Education	2.75	5%	2.88	13
12	Personal hygiene (shower, haircut, etc.)	2.9	3%	3.21	26
13	Drop-in center or day program	2.9	0%	2.77	10
14	Guardianship (financial)	2.95	6%	2.76	9
15	Job training	2.97	3%	2.88	14
16	Help with finding a job or getting employment	3	5%	3.00	17
17	Clothing	3.03	3%	3.40	31
18	Family counseling	3.03	0%	2.85	12
19	Welfare payments	3.03	0%	2.97	16
20	SSI/SSD process	3.04	2%	3.02	19
21	Discharge upgrade	3.05	0%	2.90	15
22	Help with medication	3.07	2%	3.18	24
23	Women's health care	3.11	3%	3.09	21
24	Treatment for dual diagnosis	3.12	0%	3.01	18
25	Help getting needed documents or identification	3.13	3%	3.16	23
26	Services for emotional or psychiatric problems	3.14	5%	3.20	25
27	Food	3.19	5%	3.56	35
28	Treatment for substance abuse	3.25	14%	3.30	28
29	Detoxification from substances	3.26	8%	3.11	22
30	VA disability/pension	3.3	5%	3.33	29
31	AIDS/HIV testing/counseling	3.37	0%	3.38	30
32	Spiritual	3.38	2%	3.30	27
33	TB treatment	3.55	0%	3.45	33
34	TB testing	3.56	0%	3.58	36
35	Medical services	3.58	5%	3.55	34
36	Hepatitis C testing	3.72	2%	3.41	32

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.84	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.18	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.05	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.81	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.97	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.97	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.75	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.73	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.61	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.38	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.11	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.35	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.9	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.83	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.02	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.22	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.85	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.88	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.88	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.98	1.84

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CHALENG 2004 Survey: VAM&ROC Wichita, KS - 452

VISN 15

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 250

2. Point-in-time estimate of Veterans who are Chronically Homeless: 111

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **250** (point-in-time estimate of homeless veterans in service area) **X 46%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 96%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 111** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	150	80
Transitional Housing Beds	30	50
Permanent Housing Beds	40	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 6

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Continue to support and use current housing support agencies applying for grants through VA and other federal agencies. Work with Beacon House (Veterans of Vietnam) when they decide to start a house.
Long-term, permanent housing	Continue working with veterans and explain how and when to apply for social security and VA benefits. Identify more apartments with subsidized rent agreements.
Dental Care	Continue to explain eligibility for veterans that remain in rehabilitation for 60+ days. Work is identifying dentists and/or agencies that will provide services to low-income people.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 20 Non-VA staff Participants: 95%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.11	21%	2.34	2
2	Eye care	2.47	0%	2.65	5
3	Help with transportation	2.58	11%	2.82	11
4	Glasses	2.63	5%	2.67	6
5	Long-term, permanent housing	2.67	42%	2.25	1
6	Halfway house or transitional living facility	2.72	11%	2.76	8
7	Help managing money	2.79	0%	2.71	7
8	Job training	2.84	16%	2.88	14
9	Guardianship (financial)	2.89	5%	2.76	9
10	Help with finding a job or getting employment	2.89	11%	3.00	17
11	Child care	2.95	0%	2.39	3
12	Legal assistance	2.95	0%	2.61	4
13	Emergency (immediate) shelter	3.06	16%	3.04	20
14	Help with medication	3.06	5%	3.18	24
15	Discharge upgrade	3.07	0%	2.90	15
16	Family counseling	3.11	0%	2.85	12
17	SSI/SSD process	3.11	5%	3.02	19
18	Education	3.15	0%	2.88	13
19	Spiritual	3.16	11%	3.30	27
20	Help getting needed documents or identification	3.21	0%	3.16	23
21	Treatment for dual diagnosis	3.22	5%	3.01	18
22	Hepatitis C testing	3.32	0%	3.41	32
23	Services for emotional or psychiatric problems	3.42	0%	3.20	25
24	Detoxification from substances	3.44	0%	3.11	22
25	Treatment for substance abuse	3.47	5%	3.30	28
26	Welfare payments	3.47	0%	2.97	16
27	Personal hygiene (shower, haircut, etc.)	3.58	0%	3.21	26
28	Women's health care	3.58	0%	3.09	21
29	VA disability/pension	3.58	0%	3.33	29
30	Medical services	3.63	0%	3.55	34
31	Clothing	3.68	5%	3.40	31
32	Drop-in center or day program	3.74	5%	2.77	10
33	Food	3.79	11%	3.56	35
34	AIDS/HIV testing/counseling	4	0%	3.38	30
35	TB treatment	4.05	5%	3.45	33
36	TB testing	4.21	5%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.05	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.8	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.26	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.4	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.32	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.21	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.1	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.95	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.53	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.06	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.24	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.41	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.65	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.72	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.12	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.5	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.59	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.88	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2	1.84

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CHALENG 2004 Survey: VAMC Kansas City, MO - 589

VISN 15

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1800

2. Point-in-time estimate of Veterans who are Chronically Homeless: 689

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1800** (point-in-time estimate of homeless veterans in service area) **X 44%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 87%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 689** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	375	0
Transitional Housing Beds	365	10
Permanent Housing Beds	0	80

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 10

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Identify one potential program to use for long term, permanent housing.
Job Training	Explore possibility of increasing use of existing VA community job training program.
Transitional living facility	Identify a new resource for potential use as a transitional living facility/halfway house.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 16 Non-VA staff Participants: 100%
Homeless/Formerly Homeless: 6%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.07	50%	2.25	1
2	Child care	2.27	0%	2.39	3
3	Help with transportation	2.33	17%	2.82	11
4	Help with finding a job or getting employment	2.47	17%	3.00	17
5	Help getting needed documents or identification	2.53	0%	3.16	23
6	Halfway house or transitional living facility	2.6	8%	2.76	8
7	Job training	2.6	25%	2.88	14
8	Legal assistance	2.6	0%	2.61	4
9	Women's health care	2.67	8%	3.09	21
10	Glasses	2.73	0%	2.67	6
11	Help managing money	2.73	8%	2.71	7
12	Emergency (immediate) shelter	2.79	0%	3.04	20
13	Dental care	2.79	0%	2.34	2
14	Education	2.79	0%	2.88	13
15	Drop-in center or day program	2.87	8%	2.77	10
16	SSI/SSD process	2.87	17%	3.02	19
17	Eye care	2.93	0%	2.65	5
18	Services for emotional or psychiatric problems	3	0%	3.20	25
19	Guardianship (financial)	3	0%	2.76	9
20	Welfare payments	3.07	0%	2.97	16
21	Discharge upgrade	3.07	0%	2.90	15
22	Treatment for substance abuse	3.13	17%	3.30	28
23	Treatment for dual diagnosis	3.13	0%	3.01	18
24	Family counseling	3.13	0%	2.85	12
25	Detoxification from substances	3.14	0%	3.11	22
26	Personal hygiene (shower, haircut, etc.)	3.2	0%	3.21	26
27	VA disability/pension	3.2	0%	3.33	29
28	Help with medication	3.27	0%	3.18	24
29	TB treatment	3.33	0%	3.45	33
30	AIDS/HIV testing/counseling	3.4	0%	3.38	30
31	Food	3.47	8%	3.56	35
32	Clothing	3.47	0%	3.40	31
33	Medical services	3.47	0%	3.55	34
34	Spiritual	3.47	8%	3.30	27
35	Hepatitis C testing	3.5	0%	3.41	32
36	TB testing	3.6	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.27	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.4	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.33	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.27	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.53	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.6	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.36	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.43	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.43	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.07	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.86	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.14	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.62	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.5	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.64	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.46	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.38	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.23	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.38	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.29	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Marion, IL - 609

VISN 15

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 70

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **70** (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	125	20
Transitional Housing Beds	223	50
Permanent Housing Beds	1251	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 1

3. CHALENG Point of Contact Action Plan for FY 2005

Medical Services	Plan for a Stand Down to occur by August 2005.
Help with Transportation	Plan for a Stand Down to occur by August 2005.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 12 Non-VA staff Participants: 100%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Drop-in center or day program	2.13	0%	2.77	10
2	Halfway house or transitional living facility	2.2	11%	2.76	8
3	Long-term, permanent housing	2.2	67%	2.25	1
4	Emergency (immediate) shelter	2.6	44%	3.04	20
5	Help with transportation	2.78	0%	2.82	11
6	Child care	2.78	22%	2.39	3
7	Help with medication	3	0%	3.18	24
8	Job training	3	0%	2.88	14
9	Detoxification from substances	3.1	0%	3.11	22
10	Welfare payments	3.1	0%	2.97	16
11	Legal assistance	3.1	11%	2.61	4
12	Dental care	3.11	11%	2.34	2
13	Help managing money	3.11	0%	2.71	7
14	Discharge upgrade	3.13	0%	2.90	15
15	AIDS/HIV testing/counseling	3.22	0%	3.38	30
16	Help with finding a job or getting employment	3.22	11%	3.00	17
17	Guardianship (financial)	3.25	0%	2.76	9
18	Personal hygiene (shower, haircut, etc.)	3.3	0%	3.21	26
19	Eye care	3.33	0%	2.65	5
20	Glasses	3.33	0%	2.67	6
21	SSI/SSD process	3.44	11%	3.02	19
22	Help getting needed documents or identification	3.44	0%	3.16	23
23	Education	3.44	0%	2.88	13
24	Treatment for substance abuse	3.5	0%	3.30	28
25	Medical services	3.5	11%	3.55	34
26	Family counseling	3.56	0%	2.85	12
27	Women's health care	3.6	0%	3.09	21
28	TB testing	3.6	0%	3.58	36
29	TB treatment	3.6	0%	3.45	33
30	Hepatitis C testing	3.67	0%	3.41	32
31	Spiritual	3.67	0%	3.30	27
32	Clothing	3.7	0%	3.40	31
33	VA disability/pension	3.78	0%	3.33	29
34	Food	3.8	0%	3.56	35
35	Treatment for dual diagnosis	3.86	0%	3.01	18
36	Services for emotional or psychiatric problems	4	0%	3.20	25

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.36	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.27	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.6	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.82	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.67	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.44	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.17	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.36	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.82	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.91	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.91	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.58	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.91	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.82	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.45	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.55	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.45	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.55	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Poplar Bluff, MO - 647

VISN 15

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 50

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **50** (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	5	10
Transitional Housing Beds	0	5
Permanent Housing Beds	0	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Help with Transportation	Continue efforts to advocate for community transportation assistance for low-income veterans. We plan to address this ongoing need at our monthly Butler County Resource Council Meeting. I will stress this need is especially important for veterans who are seeking employment in our community and surrounding areas.
Dental Care	Continue referrals to John J. Pershing VAMC Dental Clinic based on VA Directive 2002-080. Our dental clinic has been eager to serve homeless veterans who meet eligibility criteria. I will discuss the need for dental services at our next CRC meeting and request that we invite community dentists and hygienists.
Long-term, permanent housing	Working on several contacts with residential care facilities which have expressed willingness to help veterans. In our rural community we are working with agencies located 1-2 hours away from VA medical center. We have also contacted several independent living facilities which are also eager to assist homeless veterans.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 11 Non-VA staff Participants: 27%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Help with transportation	1.78	56%	2.82	11
2	Drop-in center or day program	2	0%	2.77	10
3	Child care	2	0%	2.39	3
4	Long-term, permanent housing	2.2	11%	2.25	1
5	Education	2.33	22%	2.88	13
6	Legal assistance	2.56	0%	2.61	4
7	Dental care	2.7	11%	2.34	2
8	Eye care	2.7	11%	2.65	5
9	Glasses	2.82	0%	2.67	6
10	Discharge upgrade	3	0%	2.90	15
11	Halfway house or transitional living facility	3.1	0%	2.76	8
12	Help managing money	3.1	11%	2.71	7
13	Welfare payments	3.11	0%	2.97	16
14	Spiritual	3.22	0%	3.30	27
15	Job training	3.27	0%	2.88	14
16	Help with finding a job or getting employment	3.3	11%	3.00	17
17	Clothing	3.5	0%	3.40	31
18	Emergency (immediate) shelter	3.55	0%	3.04	20
19	Help with medication	3.56	0%	3.18	24
20	SSI/SSD process	3.56	0%	3.02	19
21	TB testing	3.6	0%	3.58	36
22	TB treatment	3.6	0%	3.45	33
23	Family counseling	3.64	0%	2.85	12
24	Personal hygiene (shower, haircut, etc.)	3.7	0%	3.21	26
25	VA disability/pension	3.7	11%	3.33	29
26	Guardianship (financial)	3.7	11%	2.76	9
27	Food	3.82	11%	3.56	35
28	Help getting needed documents or identification	3.88	0%	3.16	23
29	Detoxification from substances	3.9	11%	3.11	22
30	Medical services	3.9	0%	3.55	34
31	AIDS/HIV testing/counseling	3.9	0%	3.38	30
32	Hepatitis C testing	3.9	0%	3.41	32
33	Treatment for substance abuse	4	11%	3.30	28
34	Services for emotional or psychiatric problems	4	11%	3.20	25
35	Treatment for dual diagnosis	4.11	0%	3.01	18
36	Women's health care	4.4	0%	3.09	21

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.73	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.4	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.4	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.3	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.44	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.22	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.56	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.33	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.4	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.75	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	3	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.4	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.6	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.8	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.8	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.4	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.6	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.8	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.8	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.4	1.84

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CHALENG 2004 Survey: VAMC St. Louis, MO - 657

VISN 15

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 9187

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1559

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **9187** (point-in-time estimate of homeless veterans in service area) **X 18%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 95%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1559** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	790	75
Transitional Housing Beds	750	50
Permanent Housing Beds	200	150

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Seek funding for shelters. Have more shelter staff work on assessment. Provide education on shelter location and admission process. Bring in community resources. Extend shelter hours. Assess and modify housing zoning codes to promote affordable housing. Promote public education and political lobbying. Coordinate with local governments to acquire abandoned properties for housing.
Transitional living facility	Identify partners and funding sources for transitional housing. Educate community on needs and issues. Explore rental subsidy programs.
Long-term, permanent housing	Develop funding resources for permanent housing. Educate community about need. Explore use of incentives (e.g., tax breaks) to promote development of affordable housing.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 161 Non-VA staff Participants: 85%
Homeless/Formerly Homeless: 23%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.05	11%	2.34	2
2	Long-term, permanent housing	2.07	30%	2.25	1
3	Child care	2.24	0%	2.39	3
4	Eye care	2.31	2%	2.65	5
5	Halfway house or transitional living facility	2.33	17%	2.76	8
6	Glasses	2.36	2%	2.67	6
7	Legal assistance	2.37	3%	2.61	4
8	Discharge upgrade	2.43	4%	2.90	15
9	Guardianship (financial)	2.46	4%	2.76	9
10	Drop-in center or day program	2.48	4%	2.77	10
11	Help managing money	2.49	4%	2.71	7
12	Emergency (immediate) shelter	2.5	22%	3.04	20
13	Family counseling	2.54	2%	2.85	12
14	Help with transportation	2.64	7%	2.82	11
15	Treatment for dual diagnosis	2.7	4%	3.01	18
16	Welfare payments	2.71	1%	2.97	16
17	Education	2.72	4%	2.88	13
18	SSI/SSD process	2.73	4%	3.02	19
19	Job training	2.76	8%	2.88	14
20	Personal hygiene (shower, haircut, etc.)	2.79	0%	3.21	26
21	Services for emotional or psychiatric problems	2.87	11%	3.20	25
22	Help with finding a job or getting employment	2.87	7%	3.00	17
23	VA disability/pension	2.9	6%	3.33	29
24	Spiritual	2.92	7%	3.30	27
25	Women's health care	2.94	2%	3.09	21
26	Help getting needed documents or identification	2.97	0%	3.16	23
27	Food	3.01	6%	3.56	35
28	Detoxification from substances	3.01	6%	3.11	22
29	Help with medication	3.01	4%	3.18	24
30	Clothing	3.08	4%	3.40	31
31	Treatment for substance abuse	3.1	9%	3.30	28
32	AIDS/HIV testing/counseling	3.13	1%	3.38	30
33	Hepatitis C testing	3.16	1%	3.41	32
34	TB treatment	3.21	0%	3.45	33
35	Medical services	3.41	4%	3.55	34
36	TB testing	3.47	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.13	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.75	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.44	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.55	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.4	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.39	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.25	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.29	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.82	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.87	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.96	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.62	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.51	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.6	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.82	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.64	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.62	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.6	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.59	1.84

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VAMC Topeka - 677

VISN 15

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 150

2. Point-in-time estimate of Veterans who are Chronically Homeless: 22

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **150** (point-in-time estimate of homeless veterans in service area) **X 16%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 89%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 22** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	60	10
Transitional Housing Beds	80	10
Permanent Housing Beds	500	20

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 6

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Will continue to partner with our local and statewide homeless coalitions, specifically in the Continuum of Care process to maximize use of existing resources and to apply for additional assistance such as federal funds for new housing options.
Dental Care	Will continue to work with our VA Dental Services to "qualify" homeless veterans for services. Will begin working with new statewide agency, Oral Health Kansas, which is organizing oral health care clinics around the state.
Job Training	We have been without a DVOP representative on campus for over a year. Will work to get a staff person from the local Workforce Center on a part-time basis. Will work with state vocational rehabilitation and other agencies to develop opportunities for veterans to get training and employment opportunities.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 37 Non-VA staff Participants: 68% Homeless/Formerly Homeless: 46%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.11	39%	2.34	2
2	Glasses	2.49	6%	2.67	6
3	Long-term, permanent housing	2.78	36%	2.25	1
4	Eye care	2.78	6%	2.65	5
5	Guardianship (financial)	2.89	3%	2.76	9
6	Child care	2.91	0%	2.39	3
7	Help with transportation	3.14	3%	2.82	11
8	Discharge upgrade	3.15	6%	2.90	15
9	Welfare payments	3.17	3%	2.97	16
10	SSI/SSD process	3.17	3%	3.02	19
11	Family counseling	3.22	6%	2.85	12
12	Women's health care	3.26	0%	3.09	21
13	VA disability/pension	3.27	3%	3.33	29
14	Legal assistance	3.29	6%	2.61	4
15	Job training	3.32	11%	2.88	14
16	Drop-in center or day program	3.37	0%	2.77	10
17	Education	3.4	8%	2.88	13
18	Help with finding a job or getting employment	3.43	8%	3.00	17
19	Help managing money	3.46	0%	2.71	7
20	Help getting needed documents or identification	3.49	0%	3.16	23
21	TB treatment	3.53	0%	3.45	33
22	Hepatitis C testing	3.61	3%	3.41	32
23	Help with medication	3.62	6%	3.18	24
24	AIDS/HIV testing/counseling	3.76	0%	3.38	30
25	Halfway house or transitional living facility	3.78	8%	2.76	8
26	Treatment for dual diagnosis	3.78	6%	3.01	18
27	TB testing	3.78	3%	3.58	36
28	Detoxification from substances	3.86	0%	3.11	22
29	Medical services	3.89	8%	3.55	34
30	Personal hygiene (shower, haircut, etc.)	3.94	3%	3.21	26
31	Treatment for substance abuse	4.03	3%	3.30	28
32	Clothing	4.05	0%	3.40	31
33	Spiritual	4.06	3%	3.30	27
34	Services for emotional or psychiatric problems	4.11	3%	3.20	25
35	Food	4.28	6%	3.56	35
36	Emergency (immediate) shelter	4.33	3%	3.04	20

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

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Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.18	4.05
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Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.75	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.56	1.75
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Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.93	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.81	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.67	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.33	1.77
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